Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: KILLEEN INJURY CLINIC, INC. 5931 DESCO DR. DALLAS, TX. 75225	MFDR Tracking #: M4-09-2867-01
Respondent Name and Box #: MIDWEST EMPLOYERS CASUALTY CO. REP. BOX # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…Ms. Fleming's extent of injury was resolved per the CCH held on 05/27/08…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $3612.66
3. CMS 1500s
4. EOBs
5. CCH Decision and Order
6. Pre-authorization letters
7. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The treatments and charges that are the subject of this dispute are for body parts/conditions that DWC has determined are not part of the compensable injury…."

Principle Documentation:

1. Response to DWC 60
2. CCH Decision and Order

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
11-20-07	90806 90880	W12 W12	1, 2, 3, 4, & 5 1, 2, 3, 4, & 5	$0.00 $0.00
12-7-07	97750-FC (x16 units/4 hours)	W12	1,2,3,4,6,7, & 8	$0.00
1-2-08	97545-WH-CA 97546-WH-CA (x6 units/hours)	W12 & 24 W12 & 62	1,2,3,4,6,7, & 8	$0.00 $0.00
1-4-08 1-16-08 1-25-08	97545-WH-CA 97546-WH-CA (x6 units/hours)	W12 62 62	1,2,3,4,6,7, & 8	$0.00 $0.00 $0.00
1-11-08	97546-WH-CA (x6 units/hours)	62	1,2,3,4,6,7, & 8	$0.00
1-23-08	97750-FC (x12 units/3 hours)	62 & 42	1,2,3,4,6,7, & 8	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied/reduced by the Respondent with reason codes "W12" (extent of injury-not finally adjudicated), "24" (payment for charges adjusted, charges are covered under a capitation agreement/managed care plan/this line was included in the reconsideration of this previously reviewed bill), "62" (payment denied/reduced for absence of, or exceeded, pre-certification/authorization/this line was included in the reconsideration of this previously reviewed bill), and "42" (charges exceed our fee schedule or maximum allowable amount/this line was included in the reconsideration of this previously reviewed bill).
2. It was confirmed by the Division that both parties agree that there is no managed care plan or PPO contract in effect for these dates of service.
3. Per a Contested Case Hearing (CCH) held on May 27, 2008, it is noted that the carrier had timely accepted a bilateral biceps strain injury on May 10, 2006. The compensable injury did not extend to include the cervical spine, bilateral shoulders, or depression. Carrier is/was liable for the medical benefits of the compensable injury only.
4. A review of the CMS 1500 forms identify that the Requestor billed with the ICD-9 code of '840'- sprains and strains of shoulder and upper arm; which by descriptor includes avulsion of: joint capsule, ligament, muscle, tendon~ hemarthrosis of: joint capsule, ligament, muscle, tendon~ laceration of: joint capsule, ligament, muscle, tendon~ rupture of: joint capsule, ligament, muscle, tendon~ sprain of: joint capsule, ligament, muscle, tendon~ strain of: joint capsule, ligament, muscle, tendon~ tear of: joint capsule, ligament, muscle, tendon.
5. By descriptor, CPT code 90806 is for individual psychotherapy and 90880 is for hypnotherapy. Although pre-authorized, being that the carrier disputed depression and this condition was upheld at the CCH as non-compensable, payment can not be recommended for these CPT codes.
6. A review of the submitted documentation identifies that treatment was performed to the compensable area (s) and to the non-compensable area (s). The Division has no way to deduce the amount of time of the treatment that was performed on the compensable area (s) vs. the non-compensable area (s) and therefore is unable to prorate any payment recommendation.
7. Moreover, Rule 133.307 (e) (2), the Division may raise issues in the MDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and Division rules. In accordance with the American Medical Association (AMA) ICD-9 descriptor of '840', a 4th digit is required for the billing of this diagnosis code and it is not to be billed alone as only '840'. It is noted that the carrier and the carrier's utilization review agent adherently accepted the '840' diagnosis code billing. Being that the Requestor has utilized/billed '840' on all of it's CMS 1500 forms, the billing of this code renders these bills as 'incomplete' and the Division is unable to order any monetary reimbursement on incomplete medical bills.
8. Pursuant to Rule 133.20 (c), "a health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.202, 133.307, 133.20
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	10-14-09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.